**UNM Orthopaedics Health History**

\*\*\*This form will become part of your medical record. Please

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of REFERRING medical provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have, or have you ever had, any of the following **MEDICAL PROBLEMS:** | Circle your answer: | | List details to these or any **OTHER** Medical Problems you have or have had: |
| Heart attack  High blood pressure  High cholesterol  Diabetes  Stroke  Asthma  Emphysema/COPD  Ulcers/Reflux  Rheumatoid arthritis  Gout  Seizures/Epilepsy  Thyroid disease  Hepatitis  HIV/AIDS  Cancer | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO | |  |
| List any **DRUG ALLERGIES:** | | | |
|  | | | |
| Circle any of the following if you are ALLERGIC:  Iodine IV Contrast Shellfish Latex | | | |
| List any **MEDICATIONS**  you are taking: | | | |
|  | |  | |
| **SOCIAL HISTORY:**  Are you employed? YES NO  Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last worked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do or did you ever smoke? YES NO \_\_\_\_\_Packs per day for\_\_\_\_\_\_\_ years  Did you quit? YES NO If so, when did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other tobacco/nicotine products? YES NO What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Drink alcohol? YES NO How much and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  History of illegal drugs/substance abuse? YES NO  What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you: Single Married Divorced Separated Widowed  Do you live alone? YES NO  Do you Exercise? Never Rarely Weekly Daily  What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**MD Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Form**

fill out as accurately as possible.\*\*\*

**Age:**\_\_\_\_\_\_\_ Are you **RIGHT** or **LEFT** handed?

(MD, DO, PA, RNP, chiropractor)

|  |  |  |
| --- | --- | --- |
| List any **SURGERIES** you have had and, if known, the **YEAR** and the name of the Surgeon: | | |
|  | | |
| **FAMILY HISTORY**  Do any of your grandparents, parents or siblings have any of the following: | | |
| Diabetes  High blood pressure  Heart attack  Stroke  Rheumatoid arthritis  Bleeding disorders  Cancer | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO | |
| **REVIEW OF SYSTEMS:**  Do you have NOW, or have you had RECENTLY, problems with any of the following: | | Circle your answer: |
| Fevers, chills, weight loss  Eyes  Ears, Nose, Throat  Teeth, Mouth  Chest pain, Heart Problems  Shortness of Breath, Lungs  Constipation, Diarrhea  Urinary tract infection  Joint pain, Joint stiffness  Skin rashes, lesions  Migraines, Headaches  Blackouts/Falling  Balance problems  Psychological problems/Depression  High cholesterol  Diabetes  Bleeding disorders  Blood clots, DVT  Seasonal allergies | | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO |
| Patient Label | | |